Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN2351AGC	A. BUILDING _____ B. WING _____	09/30/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEE HIVE HOMES OF LOVELOCK, LLC	575 FARM DISTRICT ROAD FERNLEY, NV 89408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 9/30/08. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 10 Residential Facility for Group beds for elderly and disabled persons, Category I residents. The census at the time of the survey was 10. Ten resident files were reviewed and seven employee files were reviewed. One discharged resident file was reviewed. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.	Y 000		
YA101 SS=E	449.200(1)(a-f)Personnel Files NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (a) The name, address, telephone number and social security number of the employee; (b) The date on which the employee began his employment at the residential facility; (c) Records relating to the training received by the employee; (d) The health certificates required pursuant to chapter 441 of NAC for the employee; (e) Evidence that the references supplied by the employee were checked by the residential facility; and	YA101		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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YA101	Continued From page 1 (f) Evidence of compliance with NRS 449.176 to 449.185, inclusive. This Regulation is not met as evidenced by: Based on record review on 9/30/08, the facility failed to ensure 2 of 7 employees met the requirements for physician physicals and criminal background checks. Findings include: Employee #4: The employee was originally hired on 6/1/01, quit in November 2006 and was rehired on 9/12/07. There was a 10-month period of time that the employee did not work at the facility. The employee's file contained a physician's physical from 2001, but not one in 2007 prior to being rehired. The employee's fingerprints and background check were completed in 2006. New fingerprints and a background check were not completed when the employee was rehired by the facility. Employee #5: The employee was originally hired on 12/7/04, quit on 7/15/06 and was rehired on 6/26/08. There was a 11-month period of time that the employee did not work at the facility. The employee's file contained a physician's physical from 2004, but not one in 2008 prior to being rehired. The employee's fingerprints and background check were completed in 2004. New fingerprints and a background check were not completed when the employee was rehired by the facility. This is a repeat deficiency from the 9/24/07	YA101		

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YA101	Continued From page 2 annual State Licensure survey. Severity: 2 Scope: 2	YA101		